SECTION I: TRISERVICE HAPPENINGS

1. **EASIII 9.2 RELEASE.** EDS is in the process of transmitting the 9.2 release to all sites. Below is a very high level overview of what you can expect with this release:

a. The Rollover ASD Table process has been modified to check all four CHCS-specific files (DMIS-ID Table, MEPRS Master Table, ASD Table, and the SAS Detail File).

b. The Occupation Code Table was updated to correct data errors that occurred with the Release 9.1 fix routine that updated the table.

c. Numeric characters are now allowed at the fourth level MEPRS code, and # signs with alphabet or numeric characters in MEPRS Codes are allowed in System-Generated SAS options.

d. Some APV patients receive subsistence from the Nutrition Service, and the partial meals need to be accounted for. Therefore, the SAS/MEPR Edit File has been modified to allow B and C MEPRS codes on SAS 012, in addition to A, FEC, and FEF.

e. Prior to this release, when a user processed a prior fiscal year's financial batch merge, current year's information was going into the prior year's SASs for the Army. Army salary SASs, including 022 and 025, were affected. A fix routine was added to ensure that the current year's information will only go into the current year's SASs.

2. **AMBULATORY PROCEDURE VISIT.** Didn't this new policy just make our MEPRS lives complete? Here are some additional comments that hopefully will clear up a few gray areas:

a. The B**5 codes will appear on SASs 002 and 003.

b. A patient has an APV performed and then his/her condition deteriorates necessitating admission. You will count an APV against the B**5 code because the procedure was actually performed. You will also count an admission and occupied bed day against the same patient because the provider admitted the patient.

c. A patient is scheduled for an APV, is on the APU, and is then found not eligible for the procedure because he ate, is ill, or physician cancels. You will not count an APV, however, you will record the minutes of service under the B**5.

d. Procedures performed in the clinic are not counted as APVs. Only those procedures performed in the APU or extended care areas are counted as APVs.

e. It is stated in the DODI 6025.8 that Commanders of MTFs where APVs are performed shall be required to develop a facility-specific approved list of ambulatory procedures that are organized and coded according to ICD-9 diagnoses and CPT procedure coding. This list of procedures shall reflect accepted medical practice local capabilities.

f. The CHCS PAS module will count APVs as visits. This information is then forwarded to the Ambulatory Data System (ADS). Outpatient providers use the ADS optical mark reader (OMR) form to record the ambulatory same day surgery CPT procedures and diagnoses. Additionally, on the encounter form they indicate Ambulatory Surgery as an Appointment Status. ADS captures and reports these under the appropriate B**5 MEPRS code. MEPRS will only report the following information against the B**5 code:

(1) Physician Time

(2) Pre-procedure and immediate post procedure care provided by the MTF. For example, radiology tests orders in support of the ambulatory surgery.

(3) Ancillary and Support expenses, as appropriate.

3. **AMBULATORY DATA SYSTEM.** You should report all FTEs and expenses for the administrative support staff for ADS under EKA.

SECTION II: ITEMS OF INTEREST

1. **HAIL.** We would like everyone to welcome Mr. Joseph Beckom. Joe was selected to fill the vacant Management Analyst position in our office. Joe has lived in San Antonio since 1986, but is originally from Indianapolis where he joined the U.S. Army in 1975. Joe retired from the U.S. Army in 1995 as a combat medic with assignments in Central America, Germany, Korea, and Saudi Arabia. Prior to his assignment in the MEPRS Division, Joe worked at the National Education Center as a medical instructor. Also, we would like you to welcome MSG Eric Smith. MSG Smith is our Pathology subject matter expert. He has served in the U.S. Army for the last 18 years and was previously assigned at Fort Detrick, Maryland working in the Research Lab. You can reach MSG Smith at DSN 471-9771 or Commercial 210-221-9771.

2. **BUSINESS OBJECTS - DETAILED MEPR I REPORT.** For all those site personnel who are currently or who may wish to have a Detailed MEPR I Report generated from the MEQS database. There is one available for your use in the Business Objects/MEQS III database repository. Be advised that some erroneous data will be returned when this report is run. Part 4 (Ancillary Services) and Part 5 (Support Services) are reporting the wrong information under the "Total Expenses" column. The quick fix for this:

Enter the MQ3DATA Universe.

Import from the repository DMEPR1A, ensuring associated documents are included by checking the box next to "Import with Associated Documents".

Open the query (once it has finished importing).

Modify the query by adding, from Class 6, to the end of the result objects string:

"Expenses Before Step-down",
"Expenses Stepped-down from D", and
"Expenses Stepped-down from E".

Ensure the "No Duplicates" option is selected and then run the query.

When the results return, access the EO4 report.

Access the Business Analyzer and ensure the three new objects are summed. Also ensure Cost per Performance Factor ("per fact" in Business Analyzer), and Performance Factor ("Ancillary - Weighted Procedures" in Business Analyzer) are summed.

Filter (the yellow funnel in Business Analyzer) out the Cost Pools by placing a filter under the 3d Level MEPRS Code, selecting all "D" accounts except the cost pool, ensure you have selected "Show Selected only".

Apply the changes.

Exit the Business Analyzer.

Modify the report by highlighting the data area (be sure the header is ***not* selected) of the "Total Expenses" column.

Go to "Tools", select "Variables" from the drop down menu. Generate a new variable (***name of your choosing***, cannot duplicate other variable names), the formula will be:

"<Expenses Before Step-down>+<Expenses Stepped-down from D>". Next, modify the "per fact" variable (the data area below the "Cost per Performance Factor" column), to: "If <Ancillary Weighted Procedures>>0 then <***new variable name***>/<Ancillary Weighted procedures>

The same procedures should be followed to modify the E05 report for "E" accounts. Begin at double asterisks (**). The formula would be "<Expenses Before Step-down>+<Expenses Stepped down from E>".

3. **DISCLAIMER MESSAGE.** MEDCOM has sent out a requirement that all computer systems contain a disclaimer displayed at login time stating that this is government equipment and there is no unauthorized access. The MEPRS Help Desk will install the appropriate message on all MEPRS equipment that needs it. If you have any questions, please contact the help desk at DSN 471-9764.

4. **MEPRS-SIDR-RCMAS TIMELINESS/ACCURACY METRIC.** In early December your resource managers received a memorandum on the metric being developed by the Customer Support Division/Patient Administration System and Biostatistics Activity (PASBA) in coordination with this office. The purpose of the memo was to once again emphasis the importance and benefits of accurate and timely data, along with introducing the metric. The MEDCOM will initially use the MEPRS-SIDR-RCMAS Timeliness/Accuracy Metric to determine the accuracy of direct care dispositions reported in Retrospective Case Mix Analysis System (RCMAS) and MEPRS Central. Timeliness is determined by the presence of MEPRS data in MEPRS Central within 90 days after the end of the month. The data reported to RCMAS and MEPRS Central plays a vital role in many health care management decisions made at several levels of the Military Health Services System. Therefore, we ask you to continue to work closely with your PAD personnel to ensure the information reported through the PAD and RM channels is accurate. We encourage you to establish in-house audits, and if you are not in the practice of reconciling the disposition information with PAD personnel before reporting the data, we recommend you begin to do so. Also, ensure your transmissions reach this office within 30 days after the reporting month.

3. **RESOURCE MANAGEMENT CONFERENCE.** As you know, the Resource Management Conference is scheduled for 21-25 April 1997 of which no one, including MEPRS, is centrally funded. Your MTF is

responsible for funding any and all attendees. Therefore, we recommend you convince/explain to your RM why it is just as important for you to attend. As of today, we only have 10 MEPRS people attending. For those of you who have not notified this office on whether or not you are coming to the conference, please do so ASAP. If only a handful of MEPRS people are attending, we will have to re-work the agenda.

4. **GRADUATE MEDICAL EDUCATION.** Army Graduate Medical Education (GME) and Graduate Dental Education (GDE), basic and advanced specialty training for Army practitioners, in Army health care facilities is vital to AMEDD readiness. The DODIG has released a draft audit report on reporting of GME costs. The report makes specific claims regarding the accuracy and consistency with which MEPRS data, concerning students/trainees is captured. The draft reports recommends:

a. The issuance of MEPRS data that provides a detailed methodology for allocating military personnel (at a minimum program directors and teaching physician) salaries to GME support accounts and separate reporting of GME student salaries.

b. Establishing management control procedures to ensure compliance with MEPRS guidance for allocating GME student salaries between patient care and the student salary accounts.

c. Establish procedures to ensure revised MEPRS guidance is implemented at all military medical treatment facilities.

d. Include MEPRS in management control reviews. The draft report is intended to determine if there is a "better way" to determine and allocate GME costs. There are several meetings scheduled to discuss the GME/GDE. We will keep you posted on the outcome.

5. **RESOURCE SHARING AND RESOURCE SUPPORT.** A lot of you have asked what is the difference between resource sharing and resource support. Resource sharing allows the MCS contractor under agreement with MTFs to provide personnel, equipment maintenance, and supplies needed to enhance MTF capability. Resource sharing is based on the assumption that costs associated with the provision of these resources will be more than offset by decreased TRICARE costs and result in overall cost avoidance to both the contractor and the government. Resource support is an alternative to resource sharing which provides additional flexibility to MTFs. Under resource support, the MTFs may issue a task order for personnel, equipment, equipment maintenance, or supplies, negotiate a price with the contractor, and pay for that resource directly out of funds available to the MTF. Unlike

resource sharing, the contractor does not receive credit for workload enabled by resource support.

6. **TRANSITION OF PRIMUS CLINICS TO TRICARE OUTPATIENT CLINICS.** The one remaining PRIMUS at Fort Bragg began its conversion to a TRICARE Outpatient Clinic in October 1996. The PRIMUS Clinic will undergo the name change to TRICARE Outpatient Clinic as soon as the Managed Care Support Contract is effective for TRICARE Region 2. Forts Stewart, Benning, Hood, Belvoir, and Bragg will need to update their ASD reflecting the appropriate MEPRS code (not BHA) name change from PRIMUS to TRICARE Outpatient Clinic.

SECTION III: UNIFORM CHART OF ACCOUNTS PERSONNEL UTILIZATION SYSTEM (UCAPERS)

BORROWED MILITARY MANPOWER (BMM). In analyzing the data submitted for FY96, many facilities show available hours/FTEs to a Readiness Account for BMM. You should only report available hours to the workcenter for non-assigned individuals. If borrowed military personnel are receiving/participating in a readiness type activity, DO NOT report those hours. The purpose of having borrowed manpower is to support the MTF mission, hence, only available hours in the MTF will be captured in UCAPERS

SECTION IV: EXPENSE ASSIGNMENT SYSTEM VERSION III (EASIII)

1. **SAS 018 E ACCOUNTS WORKLOAD (SUPPORT SERVICES).** This SAS contains the performance factors for the "E" accounts. These performance factors appear on the Detail MEPR Part I. There has been some confusion based on in-house and contractor workload. If there is in-house and contract housekeeping cleaning separate areas, then put the square footage that each is cleaning on SAS 018. If there is only a COR in-house then that time and money should go to EFB and only EFB will be entered on SAS 018. If the only in-house laundry service at an MTF consists of the personnel picking up and distributing the laundry and the actual cleaning is done by contract, only put EHB on SAS 018. If the cleaning is done by a government owned facility, then all costs will be charged to EHA. This includes personnel picking up and distributing the laundry. In this instance, only EHA will be on SAS 018.

2. **CAA5.** There has been many questions regarding the use of CAA5. These are the basics: CAA5 will not appear on SAS 002 or

003. It will be on SAS 004 (Weighted Dental workload). DENTAC should be able to provide the weighted workload for CAA5. Do not count the same workload in a dental clinic and in CAA5. This would create double counting. On the Ambulatory Procedure Units' SASs (451, etc.,) CAA5 will be used with the number of patients and minutes of service.

3. **TRICARE/MANAGED CARE ADMINISTRATION (ELAA).** The rules for recording the performance factor for ELAA are as follows:

a. SAS 026. Will have ELA# on this SAS with the available FTE's from SAS 800 for ELA#.

b. SAS 760 - 767. Will have the FTE's for A, B, C, and D accounts from SAS 800.

c. SAS 018. Total available FTE's for each ELA account.

4. **OBSERVATION UNIT (DGE).** Procedures to set up an Observation Unit in MEPRS:

a. Establish that the Observation Unit meets the definition for an Ambulatory Nursing Services work center.

b. Set up procedures to collect number of patients and minutes of service by patient specialty (MEPRS code).

c. Determine if the Observation Unit will be staffed by assigned personnel or if personnel will be loaned into the unit as needed.

d. Establish an Account Processing Code (APC) to account for supply and equipment expense and personnel time.

e. The following are scenarios for patients entering the Observation Unit. (Please note that the key is whether the same provider specialty is providing the care.)

(1) Care received in the observation unit is continuation of care; not another clinic visit count. For example, patient seen in the Emergency Room (ER) and is sent to an Observation Unit but remains under the care of the ER physician will retain the specialty code of BIAA.

(2) When a patient is seen in the Emergency Room then sent to the Observation Unit under the care of a new specialty (i.e. internal medicine) the patient’s minutes of service will be charged to new specialty, i.e. BAAA.

(3) When an Ambulatory Procedure Unit patient is moved to the Observation Unit because his condition warrants a longer recovery time, the patient's minutes of service in the Observation Unit will be charged to the Ambulatory Procedure Visit specialty (B**5).

(4) When an Ambulatory Procedure Unit patient is moved to the Observation Unit and the patient is referred to another service, the minutes of service while in the APU are charged to the APV specialty. The minutes of service while in the Observation Unit under the new (referred) service are charged to the new specialty.

f. The CHCS location for the Observation Unit should be setup as with a MEPRS code of DGE*. When patients are moved to the Observation Unit, an appointment should be booked and each patient should be processed when they leave the unit. When End of Day processing is performed, a report will be printed with the time the patient entered the unit and the time that the patient left the unit. Manual calculations will have to be performed to provide minutes of service. (An ad hoc report can be created at each facility which will provide the minutes of service.)

g. For ADS questions call the DOD Coding Hotline DSN 471-0579 or 429-8921. Questions may also be addressed via cc:mail to cpt_help.

SECTION V - ARMY HEALTH CARE FINANCIAL MANAGEMENT SYSTEM (AHCFMS)

STANFINS FILE VS STANFINS TAPE. The DOIMS are slowly moving from providing a STANFINS tape to providing a STANFINS file. Kudos to Leavenworth, Womack AMC, Redstone Arsenal, West Point, Drum, Walter Reed AMC, Belvoir, Huachuca, and Meade. Soon we will have the shell that will enable you to move the file into the directory for the accept function in Batch Merge. This will be tested 19 February 1997. Each site will be notified when this shell is sent out. By using a file instead of a tape, the files will be stored in the usr2 directory and will be available for upload whenever needed. The shell will include a menu in order to select the month. This increases the criticality of the /usr2 file system and requires that UNIX file system backups must be done regularly to include the "/usr2" files. Failure to perform regular UNIX file system backups will put the STANFINS data files at risk.